

C O N F I D E N T I A L

**AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION  
to**

**COMET Program**

[including Barb Sussex, Program Manager, Clark County Department of Community Services, Mental Health  
Northwest, Clark County Council on Alcohol and Drugs (Pacific Crest Consortium)]

I \_\_\_\_\_ hereby authorize

\_\_\_\_\_  
(agency and/or name and title of person submitting referral)

to disclose to the COMET Program the information identified below.

**Confidential Information to be Disclosed** (have person initial next to 'x')

- ☒ \_\_\_\_\_ Demographic and contact information (name, phone numbers, address, social security number, current living situation, income).  
☒ \_\_\_\_\_ Current involvement in Clark County Correctional System,  
☒ \_\_\_\_\_ Current involvement in mental health services,  
☒ \_\_\_\_\_ Current involvement in chemical dependency services,.  
☒ \_\_\_\_\_ Psychiatric/psychological reports, diagnosis, prescription medication, name of attending psychiatrist and primary health care provider, most recent assessment, and treatment plan.

I understand that the purpose of the disclosure herein is to make a referral to the COMET Program. I understand that a COMET staff person may be contacting me to tell me about the program but that submitting this referral does not mean that I have to enter COMET services.

I understand that any information disclosed is protected by State and Federal Confidentiality Rules (42 CFR Part 2) and the Health Insurance Portability and Accountability Act of 1996 (HIPAA) 45 CFR, parts 160 & 164 and that these laws prohibit recipients of this information from making any further disclosure without my specific written consent. I understand that when Federal and State requirements on this subject differ, the recipients of this information will adhere to the stricter of the two regulations.

I understand that I may revoke this consent at any time except to the extent that action has been taken based upon it. This consent expires on (date) \_\_\_\_\_. If the date has not been specified, it is my intent that it expire 90 days from date of signature.

\_\_\_\_\_  
(Signature of person authorizing this release)

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Signature of witness)

\_\_\_\_\_  
(Date)

Send to: Barb Sussex, Clark County DCS, PO Box 5000, Vancouver, WA 98666. fax (360) 397- 6028, phone (360) 397-2130